OASIS ITEM:

(M0230/M0240) Diagnoses and Severity Index: List each medical diagnosis and ICD-9-CM code at the level of highest specificity (no surgical codes) for which the patient is receiving home care. Rate each condition using the following severity index. (Choose one value that represents the most severe rating appropriate for each diagnosis.) E codes (for M0240 only) or V codes (for M0230 or M0240) may be used. ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a V code is reported in place of a case mix diagnosis, then M0245 Payment Diagnosis should be completed. Case mix diagnosis is a primary or first secondary diagnosis that determines the Medicare PPS case mix group.

0 - Asymptomatic, no treatment needed at this time
1 - Symptoms well controlled with current therapy
2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring
3 - Symptoms poorly controlled, patient needs frequent adjustment in treatment and dose monitoring
4 - Symptoms poorly controlled, history of rehospitalizations

(M0230) Primary Diagnosis	ICD-9-CM	Severity Rating
a. _____	(__ __ __ . __ __)	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
(M0240) Other Diagnoses	**ICD-9-CM**	**Severity Rating**
b. _____	(__ __ __ __ . __ __)	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
c. _____	(__ __ __ __ . __ __)	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
d. _____	(__ __ __ __ . __ __)	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
e. _____	(__ __ __ __ . __ __)	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
f. _____	(__ __ __ __ . __ __)	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

DEFINITION:

- Identifies each diagnosis for which the patient is receiving home care and its ICD-9-CM code. The patient status in relation to each diagnosis (other than an E code) is categorized according to its severity. The primary diagnosis (M0230) should be the condition that is the chief reason for providing home care.
- A case mix diagnosis is a primary diagnosis that assigns patients with selected conditions to an orthopedic, diabetes, neurological, or burns/trauma group for Medicare PPS case mix assignment. The Final Regulation for home health prospective payment, July 3, 2000, includes the case mix diagnoses and is found at this site: http://www.cms.hhs.gov/providers/hhapps/hhppsfr.asp.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Follow-up

RESPONSE—SPECIFIC INSTRUCTIONS:

- No surgical codes.
- V codes can be reported in M0230. Enter V, followed by a two-digit number, decimal point, and enter any additional digits specified in the ICD-9-CM coding manual. (Remember to complete M0245 if the V code replaces a case mix diagnosis. Please see Assessment Strategies.)
- V codes can be reported in M0240(b) through (f). Leave the first space blank, enter V, followed by a two-digit number, decimal point, and any additional digits specified in the ICD-9-CM coding manual.
- E codes may be reported in M0240(b) through (f) only. Enter E followed by the three-digit number, decimal point, and fourth-digit number, as specified. If an E code is reported, do not rate its severity.
- Code at the level of highest specificity -- assign three, four, or five digits, according to current ICD-9-CM guidelines.

ASSESSMENT STRATEGIES (Cont'd for OASIS ITEM M0230/240)

Interview patient/caregiver to obtain past health history; additional information may be obtained from the physician. Review current medications and other treatment approaches.

Determine if additional diagnoses are suggested by current treatment regimen, and verify this information with the patient/caregiver and physician. Ask to what extent symptoms are controlled by current treatments. Clarify which diagnoses/symptoms have been poorly controlled in the recent past.

Assessing severity includes review of presenting signs and symptoms, type and number of medications, frequency of treatment readjustments, and frequency of contact with health care provider. Inquire about the degree to which each condition limits daily activities.

The current ICD-9-CM guidelines should be followed in coding these items.

V codes cannot be used in case mix group assignment. Effective October 1, 2003, if a provider reports a V code in M0230 in place of a case mix diagnosis, the provider has the option of reporting the case mix diagnosis in M0245.

See Attachment D to this chapter for further guidance on assigning and coding diagnoses in M0230/ M0240.

OASIS ITEM:

(M0245) Payment Diagnoses (Optional): If a V code was reported in M0230 in place of a case mix diagnosis, list the primary diagnosis and ICD-9-CM code, determined in accordance with OASIS requirements in effect before October 1, 2003 -- no V codes, E codes, or surgical codes allowed. ICD-9-CM sequencing requirements must be followed. Complete both lines (a) and (b) if the case mix diagnosis is a manifestation code or in other situations where multiple coding is indicated for the primary diagnosis; otherwise complete line (a) only.

	(M0245) Primary Diagnosis	ICD-9-CM
a.	_____	(__ __ __ . __ __)
	(M0245) First Secondary Diagnosis	ICD-9-CM
b.	_____	(__ __ __ . __ __)

DEFINITION:

A case mix diagnosis is a primary diagnosis that assigns patients with selected conditions to an orthopedic, diabetes, neurological, or burns/trauma group for Medicare PPS case mix adjustment. A case mix diagnosis may involve manifestation coding.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Follow-up

RESPONSE—SPECIFIC INSTRUCTIONS:

- V codes and E codes may not be entered in M0245 (a) or (b) as these pertain to the Medicare PPS case mix diagnosis only.
- M0245 is for patients with a payment source of Medicare traditional fee for service (M0150, response 1). M0245 should always be blank for ALL other payer sources (M0150, response 0, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, UK).
- Complete M0245 only if a V code has been reported in place of a case mix diagnosis in M0230.
- Do not complete M0245 if a V code has not been reported in M0230 in place of a case mix diagnosis.

ASSESSMENT STRATEGIES:

Select the code(s) that would have been reported as the primary diagnosis under the OASIS-B1 (8/2000) instructions:

a. No surgical codes -- list the underlying diagnosis.
b. No V codes or E codes -- list the relevant medical diagnosis.
c. If the patient's primary home care diagnosis is coded as a combination of an etiology and a manifestation code, the etiology code should be entered in M0245 (a) and the manifestation code should be entered in M0245 (b).
d. You can refer to CMS Guidelines for selecting a diagnosis under PPS at: www.cms.hhs.gov/providers/hhapps/hhdiag.pdf.

See Attachment D to this chapter for further guidance on assigning and coding diagnoses in M0245.

OASIS ITEM:

(M0250) Therapies the patient receives at home: **(Mark all that apply.)**

- ☐ 1 - Intravenous or infusion therapy (excludes TPN)
- ☐ 2 - Parenteral nutrition (TPN or lipids)
- ☐ 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)
- ☐ 4 - None of the above

DEFINITION:

Identifies whether the patient is receiving intravenous, parenteral nutrition, or enteral nutrition therapy at home.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Follow-up
Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- Include only such therapies administered at home. Exclude similar therapies administered in outpatient facilities.
- If the patient will receive such therapy as a result of this assessment (e.g., the IV will be started at this visit; the physician will be contacted for an enteral nutrition order; etc.), mark the applicable therapy.
- If a patient receives intermittent medications or fluids via an IV line (e.g., heparin or saline flush), mark Response 1. If IV catheter is present but not active (e.g., site is observed only or dressing changes are provided), do not mark Response 1.
- If any enteral nutrition is provided, mark Response 3. If a feeding tube is in place, but not currently used for nutrition, Response 3 does not apply. A flush of a feeding tube is not considered to provide nutrition.

ASSESSMENT STRATEGIES:

Determine from patient/caregiver interview, nutritional assessment, review of past health history, and referral orders. Assessment of hydration status or nutritional status may result in an order for such therapy (therapies).

OASIS ITEM:

(M0260) Overall Prognosis: BEST description of patient's overall prognosis for recovery from this episode of illness.

- ☐ 0 - Poor: little or no recovery is expected and/or further decline is imminent
- ☐ 1 - Good/Fair: partial to full recovery is expected
- ☐ UK - Unknown

DEFINITION:

Identifies the patient's expected overall prognosis for recovery at the start of this home care episode.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS:

- Note that "Good" and "Fair" are both included in Response 1.

ASSESSMENT STRATEGIES:

Interview for past health history and observe current health status. Consider diagnosis and referring physician's expectations for this patient. Based on information received from these data sources, make informed judgment regarding overall prognosis.

OASIS ITEM:

(M0270) Rehabilitative Prognosis: BEST description of patient's prognosis for functional status.

- ☐ 0 - Guarded: minimal improvement in functional status is expected; decline is possible
- ☐ 1 - Good: marked improvement in functional status is expected
- ☐ UK - Unknown

DEFINITION:

Identifies the patient's expected prognosis for functional status improvement at the start of this episode of home care.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS:

ASSESSMENT STRATEGIES:

Interview for past health history and observe the current functional status. Consider diagnosis and referring physician's expectations for this patient. Based on information received from these data sources, make informed judgment regarding rehabilitative prognosis.

OASIS ITEM:

(M0280) Life Expectancy: (Physician documentation is not required.)

☐ 0 - Life expectancy is greater than 6 months
☐ 1 - Life expectancy is 6 months or fewer

DEFINITION:

Identifies those patients for whom life expectancy is fewer than six months.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- A "Do Not Resuscitate" order does not need to be in place.

ASSESSMENT STRATEGIES:

Interview the patient/caregiver to obtain past health history. Observe current health status. Consider medical diagnosis and referring physician's expectations for patient. If the patient is frail and highly dependent on others, ask the family whether the physician has informed them about life expectancy. Based on information received from these data sources, make informed judgment regarding life expectancy.

OASIS ITEM:

(M0290) High Risk Factors characterizing this patient: **(Mark all that apply.)**

- ☐ 1 - Heavy smoking
- ☐ 2 - Obesity
- ☐ 3 - Alcohol dependency
- ☐ 4 - Drug dependency
- ☐ 5 - None of the above
- ☐ UK - Unknown *

* At discharge, omit "UK - Unknown."

DEFINITION:

Identifies specific factors that may exert a high impact on the patient's health status and ability to recover from this illness.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- Utilize agency assessment guidelines and informed professional decision-making. Consider amount and length of exposure when responding (e.g., smoking one cigarette a month may not be considered a high risk factor). Specific definitions for each of these factors do not exist.

ASSESSMENT STRATEGIES:

Interview patient/caregiver for past health history. Observe environment and current health status.

OASIS ITEM:

(M0300) Current Residence:

- ☐ 1 - Patient's owned or rented residence (house, apartment, or mobile home owned or rented by patient/couple/significant other)
- ☐ 2 - Family member's residence
- ☐ 3 - Boarding home or rented room
- ☐ 4 - Board and care or assisted living facility
- ☐ 5 - Other (specify) _____

DEFINITION:

Identifies where the patient is residing during the current home care episode (e.g., where the patient is receiving care).

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- Response 1: Dwelling considered to be the patient's own.
- Response 2: Dwelling considered to belong to family member. Patient may be a temporary or permanent resident.
- Response 3: Room rented in a larger dwelling. Patient's room may be the only one rented or one of many. No specific health-related services or supervision are provided, though meals can be included.
- Response 4: Some care or health-related services are provided in conjunction with living quarters.

ASSESSMENT STRATEGIES:

Observe the environment in which the visit is being conducted. Interview the patient/caregiver regarding others living in the residence, their relationship to the patient, and any services being provided.

OASIS ITEM:

(M0340) Patient Lives With: (Mark all that apply.)

- ☐ 1 - Lives alone
- ☐ 2 - With spouse or significant other
- ☐ 3 - With other family member
- ☐ 4 - With a friend
- ☐ 5 - With paid help (other than home care agency staff)
- ☐ 6 - With other than above

DEFINITION:

Identifies whomever the patient is living with at this time, even if the arrangement is temporary.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- "Other family member" could include in-laws, children, cousins, etc.
- "Paid help" would include help provided under a special program (e.g., Medicaid), even though the patient may not be directly paying for this help. Intermittent (e.g., a few hours each day, one to two days a week, etc.) paid help does not classify as help the patient "lives with."

ASSESSMENT STRATEGIES:

This is information all agencies need to know in planning care and services. Try to incorporate this question into the conversation, so the patient does not feel an investigation is being conducted.

OASIS ITEM:

(M0350) Assisting Person(s) Other than Home Care Agency Staff: (Mark all that apply.)

- ☐ 1 - Relatives, friends, or neighbors living outside the home
- ☐ 2 - Person residing in the home (EXCLUDING paid help)
- ☐ 3 - Paid help
- ☐ 4 - None of the above **[If None of the above, go to *M0390*] ***
- ☐ UK - Unknown **[If Unknown, go to *M0390*] ****

* At discharge, change M0390 to M0410.

** At discharge, omit "UK - Unknown."

DEFINITION:

Identifies the individuals who provide assistance to the patient (EXCLUDING the home care agency).

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- Response 3 – Paid help includes all individuals who are paid to provide assistance to the patient, whether paid by the patient, family, or a specific program (e.g., a non-agency community program). An agency other than the home care agency doing the assessment who provides assistance to the patient would be classified as paid help. A patient living in an assisted living facility receives assistance from paid help.
- If patient does not receive assistance from others, mark Response 4 – None of the above.
- If "None of the above" is selected at discharge, clinician should be directed to skip to M0410.

ASSESSMENT STRATEGIES:

If the patient mentions a friend or relative helping or coming to visit, interview to find out more about who helps patient, how often, what helpers do, etc. (applies to M0360, M0370, M0380). In obtaining the health history, interview to determine whether ADL/IADL assistance is needed. If it is, request information on whether patient receives such assistance and from whom.

OASIS ITEM:

(M0360) Primary Caregiver taking lead responsibility for providing or managing the patient's care, providing the most frequent assistance, etc. (other than home care agency staff):

- ☐ 0 - No one person **[If No one person, go to *M0390*] ***
- ☐ 1 - Spouse or significant other
- ☐ 2 - Daughter or son
- ☐ 3 - Other family member
- ☐ 4 - Friend or neighbor or community or church member
- ☐ 5 - Paid help
- ☐ UK - Unknown **[If Unknown, go to *M0390*] ****

* At discharge, change M0390 to M0410.

** At discharge, omit "UK - Unknown."

DEFINITION:

Identifies the person who is "in charge" of providing and coordinating the patient's care. A case manager hired to oversee care, but who does not provide any assistance is not considered the primary caregiver. This person may employ others to provide direct assistance, in which case "paid help" is considered the primary caregiver.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- If one person assumes lead responsibility for managing care, but another provides most frequent assistance, assess further to determine if one should be designated as primary caregiver or if Response 0 – No one person, is most appropriate.
- Response 5 – Paid help includes all individuals who are paid to provide assistance to the patient, whether paid by the patient, family, or a specific program (e.g., a non-agency community program). An agency other than the home care agency doing the assessment who provides assistance to the patient would be classified as paid help.
- If the primary caregiver is the patient himself (or herself), mark Response 0 - No one person.
- If "No one person" is selected at discharge, clinician should be instructed to go to M0410.

ASSESSMENT STRATEGIES:

From M0350, it is known that the patient receives assistance. Interview to determine whom the patient considers to be the primary caregiver. For example, ask, "Of the people who help you, is there one person who is 'in charge' of making sure things get done?" "Who would you call if you needed help or assistance?"

OASIS ITEM:

(M0370) How Often does the patient receive assistance from the primary caregiver?

- ☐ 1 - Several times during day and night
- ☐ 2 - Several times during day
- ☐ 3 - Once daily
- ☐ 4 - Three or more times per week
- ☐ 5 - One to two times per week
- ☐ 6 - Less often than weekly
- ☐ UK - Unknown *

*At discharge, omit "UK - Unknown."

DEFINITION:

Identifies the frequency of the help provided by the primary caregiver (identified in M0360).

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- Responses are arranged in order of most to least assistance received from primary caregiver.
- This item is skipped if no primary caregiver.

ASSESSMENT STRATEGIES:

Ask, in various ways, how often the primary caregiver provides various types of assistance (e.g., “How often does your daughter come by? Does she go shopping for you every week? When she is here, does she do the laundry?”). As you proceed through the assessment (particularly the ADLs and IADLs), several opportunities arise to learn details of the help the patient receives.

OASIS ITEM:

(M0380) Type of Primary Caregiver Assistance: (Mark all that apply.)

- ☐ 1 - ADL assistance (e.g., bathing, dressing, toileting, bowel/bladder, eating/feeding)
- ☐ 2 - IADL assistance (e.g., meds, meals, housekeeping, laundry, telephone, shopping, finances)
- ☐ 3 - Environmental support (housing, home maintenance)
- ☐ 4 - Psychosocial support (socialization, companionship, recreation)
- ☐ 5 - Advocates or facilitates patient's participation in appropriate medical care
- ☐ 6 - Financial agent, power of attorney, or conservator of finance
- ☐ 7 - Health care agent, conservator of person, or medical power of attorney
- ☐ UK - Unknown *

* At discharge, omit "UK - Unknown."

DEFINITION:

Identifies categories of assistance provided by the primary caregiver (identified in M0360).

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- Response 3: Includes home repair and upkeep, mowing lawn, shoveling snow, and painting.
- Response 4: Includes frequent visits or phone calls, going with patient for outings, church services, other events.
- Response 5: Takes patient to medical appointments, follows up with filling prescriptions or making subsequent appointments, etc.
- Responses 6 and 7: Legal arrangements that exist for finances or health care.

ASSESSMENT STRATEGIES:

Interview questions about types of assistance are likely to produce answers that relate to ADLs and IADLs. More specific questions need to address other aspects of assistance. At start of care, discussion of advance directives can provide information about existing legal arrangements for decision-making.

OASIS ITEM:

(M0390) Vision with corrective lenses if the patient usually wears them:

- ☐ 0 - Normal vision: sees adequately in most situations; can see medication labels, newsprint.
- ☐ 1 - Partially impaired: cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout; can count fingers at arm's length.
- ☐ 2 - Severely impaired: cannot locate objects without hearing or touching them or patient nonresponsive.

DEFINITION:

Identifies the patient's ability to see and visually manage (function) within his/her environment, wearing corrective lenses if these are usually worn.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Follow-up

RESPONSE—SPECIFIC INSTRUCTIONS:

- A magnifying glass (as might be used to read newsprint) is not an example of corrective lenses.
- Reading glasses (including "grocery store" reading glasses) are considered to be corrective lenses.
- "Nonresponsive" means that the patient is not able to respond.

ASSESSMENT STRATEGIES:

In the health history interview, ask the patient about vision problems (e.g., cataracts) and whether or not the patient uses glasses. Observe ability to locate signature line on consent form, to count fingers at arm's length and ability to differentiate between medications, especially if medications are self-administered. Be sensitive to requests to read, as patient may not be able to read though vision is adequate.

OASIS ITEM:

(M0400) Hearing and Ability to Understand Spoken Language in patient's own language (with hearing aids if the patient usually uses them):

- ☐ 0 - No observable impairment. Able to hear and understand complex or detailed instructions and extended or abstract conversation.
- ☐ 1 - With minimal difficulty, able to hear and understand most multi-step instructions and ordinary conversation. May need occasional repetition, extra time, or louder voice.
- ☐ 2 - Has moderate difficulty hearing and understanding simple, one-step instructions and brief conversation; needs frequent prompting or assistance.
- ☐ 3 - Has severe difficulty hearing and understanding simple greetings and short comments. Requires multiple repetitions, restatements, demonstrations, and additional time.
- ☐ 4 - Unable to hear and understand familiar words or common expressions consistently, or patient nonresponsive.

DEFINITION:

Identifies the patient's ability to hear and to understand spoken language, in the patient's primary language. Hearing is evaluated with the patient wearing aids if he/she usually uses them.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS:

- "Nonresponsive" means that the patient is not able to respond.

ASSESSMENT STRATEGIES:

Interaction with the patient during the assessment process provides information to answer this item. Be alert to what is required to adequately communicate with the patient. If he/she uses a hearing appliance, be sure that it is in place, has a battery, and is turned on.

A patient whose primary language differs from the clinician's requires additional evaluation. Can a family member or friend interpret? Does the agency provide an interpreter? Is another clinician (who speaks the patient's primary language) available? If an interpreter provides assistance, visit clinical documentation should note the assistance of this individual.

OASIS ITEM:

(M0410) Speech and Oral (Verbal) Expression of Language (in patient's own language):

- ☐ 0 - Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.
- ☐ 1 - Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance).
- ☐ 2 - Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.
- ☐ 3 - Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases.
- ☐ 4 - Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (e.g., speech is nonsensical or unintelligible).
- ☐ 5 - Patient nonresponsive or unable to speak.

DEFINITION:

Identifies the patient's ability to communicate verbally (by mouth) in the patient's primary language. The item does not address communicating in sign language, in writing, or by any nonverbal means. Augmented speech (e.g., a trained esophageal speaker, use of an electrolarynx) is considered verbal expression of language.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- "Nonresponsive" means that the patient is not able to respond.
- Presence of a tracheostomy requires further evaluation of the patient's ability to speak. Can the trach be covered to allow speech? If so, to what extent can the patient express him/herself?

ASSESSMENT STRATEGIES:

Interaction with the patient during the assessment process provides information to answer this item. Patient responses to interview questions are evaluated to determine speaking ability.

OASIS ITEM:

(M0420) Frequency of Pain interfering with patient's activity or movement:

- ☐ 0 - Patient has no pain or pain does not interfere with activity or movement
- ☐ 1 - Less often than daily
- ☐ 2 - Daily, but not constantly
- ☐ 3 - All of the time

DEFINITION:

Identifies frequency with which pain interferes with patient's activities, with treatment if prescribed.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Follow-up
Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- Responses are arranged in order of least to most interference with activity or movement.

ASSESSMENT STRATEGIES:

When reviewing patient's medications, the presence of medication for pain or joint disease provides an opportunity to explore the presence of pain, when the pain is the most severe, activities with which the pain interferes, and the frequency of this interference with activity or movement. Be careful not to overlook seemingly unimportant activities, e.g., the patient says she/he sits in the chair all day and puts off going to the bathroom, because it hurts so much to get up from the chair or to walk.

Evaluating the patient's ability to perform ADLs and IADLs can provide additional information about such pain.

Assessing pain in a nonverbal patient involves observation of facial expression (e.g., frowning, gritting teeth), monitoring heart rate, respiratory rate, perspiration, pallor, pupil size, irritability, or use of visual analog pain scales.

The patient's treatment for pain (whether pharmacologic or nonpharmacologic treatment) must be considered when evaluating whether pain interferes with activity or movement. Pain that is well controlled with treatment may not interfere with activity or movement at all.

OASIS ITEM:

(M0430) Intractable Pain: Is the patient experiencing pain that is not easily relieved, occurs at least daily, and affects the patient's sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions, or ability or desire to perform physical activity?

☐ 0 - No
☐ 1 - Yes

DEFINITION:

Identifies the presence of intractable pain, as defined in the item.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

ASSESSMENT STRATEGIES:

Intractable pain is pain that is ever present, may make the patient more irritable or less tolerant of frustrations, awakens her/him at night, and makes it difficult to get back to sleep. It may cause the patient to refrain from participating in activities that have been an important part of life, because she/he knows the activity will increase the pain or that the pain will be so significant that he/she can no longer enjoy the activity. A patient who has intractable pain may express much frustration (e.g., crying or anger) at how the pain is interfering with life. As you assess the patient's medications and activities, elicit whether or not the patient's pain fits these descriptions. Ask the patient if the pain is present despite taking analgesic medication regularly as prescribed.

Assessing pain in a nonverbal patient involves observation of facial expression (e.g., frowning, gritting teeth), monitoring heart rate, respiratory rate, perspiration, pallor, pupil size, irritability, or use of visual analog pain scales.